

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL DENTON</b>		c. LENGTH OF STAY IN lb <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MALISSA</b>		First <b>JANE</b>	Middle <b>ALTFATHER</b>
4. SEX <b>F</b>	5. COLOR OR RACE <b>W</b>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>Oct. 13, 1890</b>
8. AGE (in years last birthday) <b>70 yrs.</b>	9. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	10. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
13. FATHER'S NAME <b>Charles Will</b>		14. MOTHER'S MAIDEN NAME <b>Susan Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>John W. Altfather, Denton, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent carcinoma of rectum</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). <b>DUE TO</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. st. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E.C.H. Schmidt</b>		ADDRESS (Street, city or town, state) <b>2195 Westinghouse St., Denton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>E.C.H. Schmidt</b>		DATE SIGNED <b>11-20-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov. 2, 1960</b>		22b. DATE THEREOF <b>Nov. 2, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Denton</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Moore &amp; Son Denton</b>		22d. LOCATION (City, town, or county) <b>Denton, Md.</b>	
ADDRESS <b>Arthur S. Moore &amp; Son Denton</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Moore</b>



**TO HOSPITAL** by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

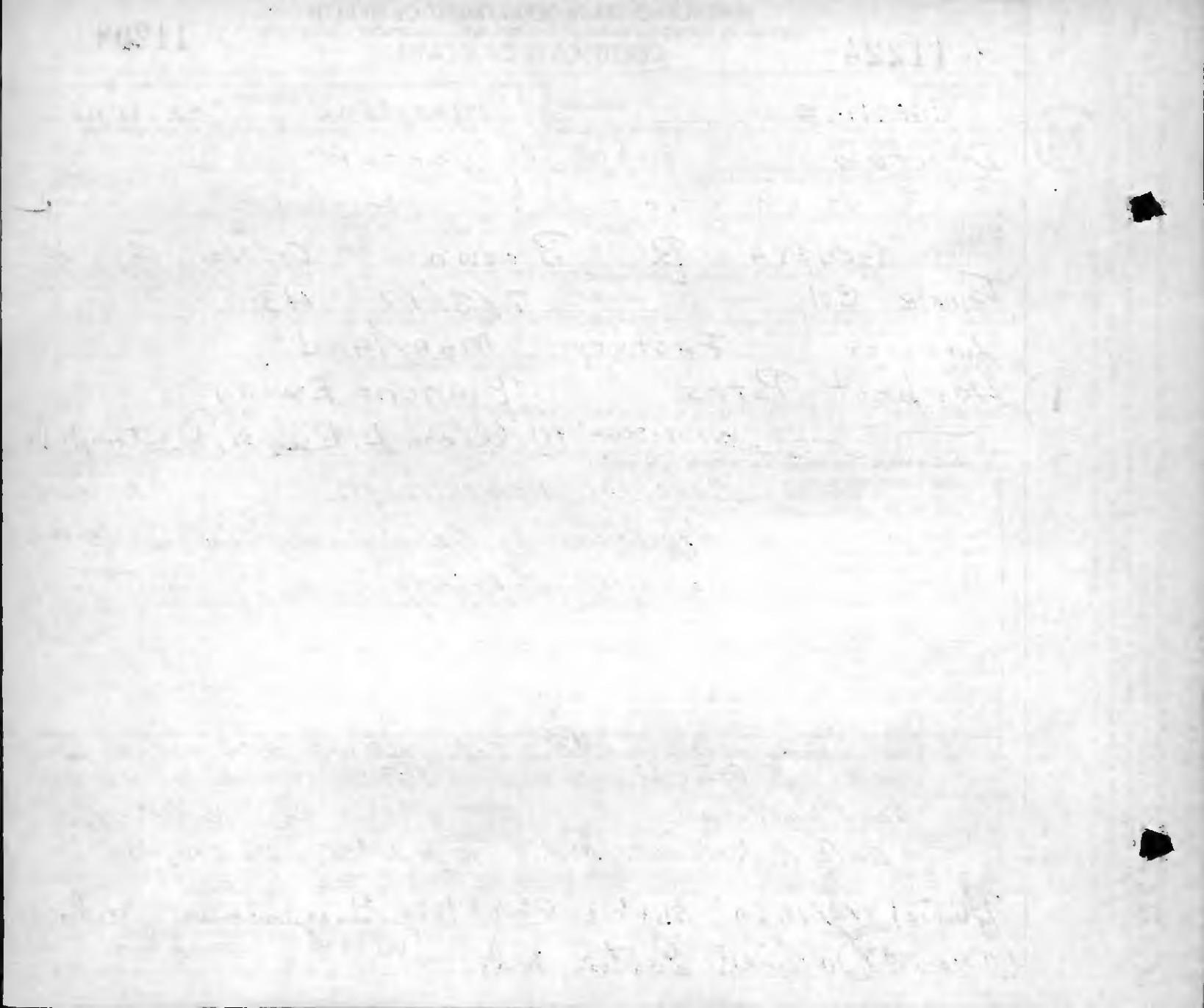
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11208

11224

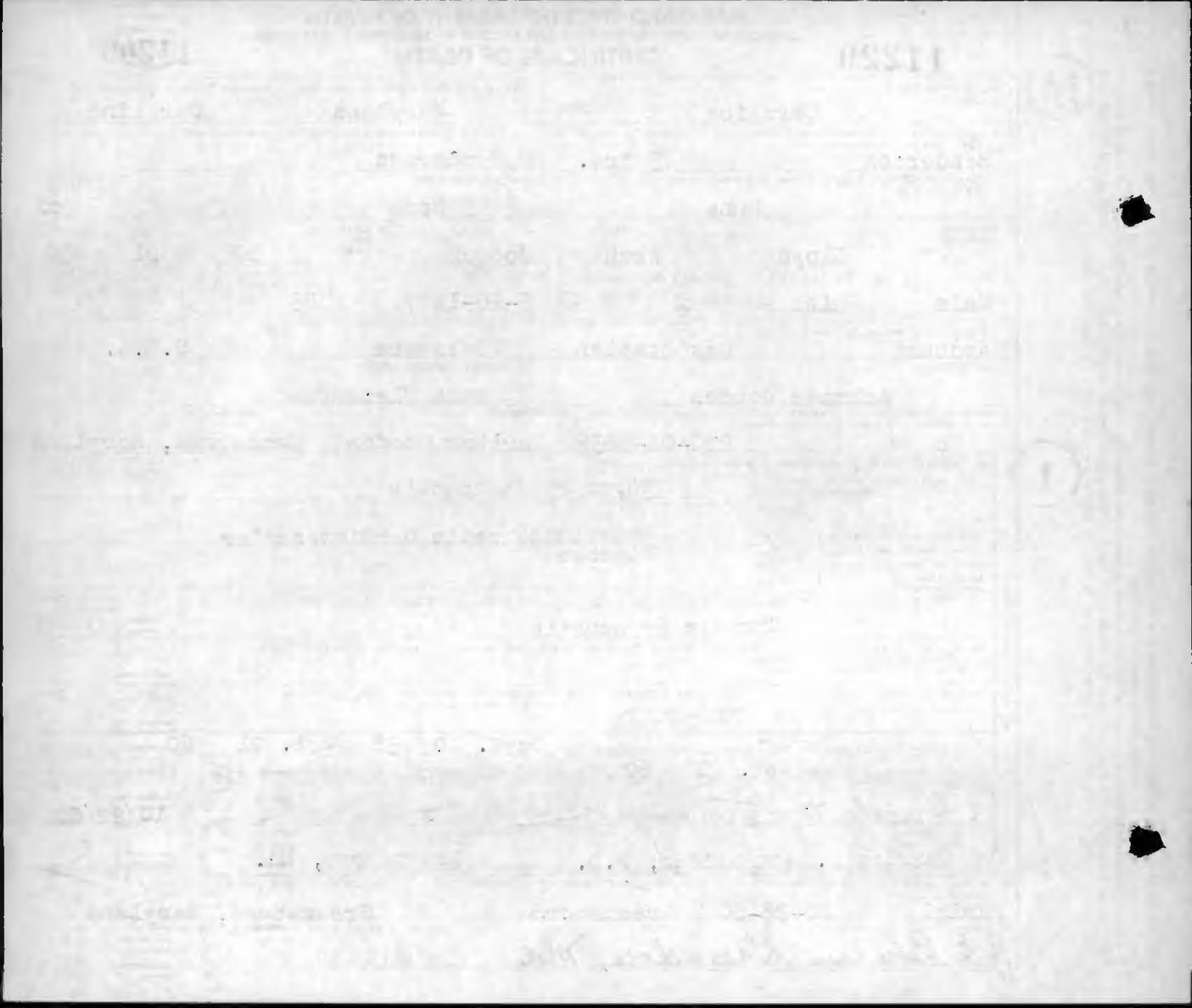
1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	c. LENGTH OF STAY IN 1b <i>21 fc</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Denton</i>	e. COUNTY <i>Caroline</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>High street</i>	e. STREET ADDRESS <i>1 High st.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Geneva B. Brown</i>	First Middle Last	4. DATE OF DEATH <i>October 10 1960</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/8/17</i>
9. AGE (In years last birthday) <i>43 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Factory</i>	12. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
13. FATHER'S NAME <i>Herbert Potts</i>	14. MOTHER'S MAIDEN NAME <i>Blanche Ewing</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>	
16. SOCIAL SECURITY NO. <i>213-18-5062</i>	17. INFORMANT <i>William A. Brown, Denton, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>53IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Hypertension, Probably essential</i> INTERVAL BETWEEN ONSET AND DEATH <i>20 min.</i>	
	(b) DUE TO <i>Unknown etiology.</i>	(c)	several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>N/A</i>	(County) <i>N/A</i>	(State) <i>N/A</i>	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>10 Oct. 1960</i> to <i>9 PM 10 Oct. 1960</i> , that (I) <del>last</del> saw the deceased alive on <i>10 Oct. 1960</i> , and that death occurred at <i>9 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Dale R. Kollman</i>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <i>16-Oct-1960</i>
22c. PHYSICIAN'S NAME (Type) <i>Dale R. Kollman, M.D.</i>	22d. ADDRESS <i>16 N. 2nd St.; Denton, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>10/15/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Burriss Cemetery</i>	23d. LOCATION (City, town, or county) <i>Grenada</i> (State) <i>md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jeanne S. DeLille Denton, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>OCT 19 1960</i>	25b. REGISTRAR'S SIGNATURE <i>Albert S. Turner</i>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

11229		11209	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Caroline</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henderson</b>		c. LENGTH OF STAY IN 1b <b>75 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. STREET ADDRESS <b>None</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lloyd</b>		First <b>Archer</b> Middle	Last <b>Gooden</b> Month <b>10</b> Day <b>21</b> Year <b>1960</b>
S. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6-16-1877</b>		9. AGE (In years last birthday) <b>83</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ambrose Gooden</b>		14. MOTHER'S MAIDEN NAME <b>Emma Clements</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-9836</b>	
17. INFORMANT <b>Carlton Gooden</b>		Address <b>Henderson, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a)		<b>Coronary Thrombosis</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<b>Arteriosclerotic Cardiovascular Disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Sept. 10 1958, to Oct. 21, 1960, that (I) (we) last saw the deceased alive on Oct. 21 1960 and that death occurred at 9A M, from the causes and on the date stated above.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from		22. SIGNATURE <b>Charles H. Stonesifer</b> M.D.	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22b. DATE SIGNED <b>10/22/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Greensboro</b>		23d. LOCATION (City, town, or county) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J E. Boulaire Greensboro, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles S. Kline</b> DATE <b>OCT 26 '60</b>	
		25b. REGISTRAR'S SIGNATURE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11210

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>CAROLINE</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>BENTON</i> 15 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>BENTON</i>	
3. NAME OF DECEASED (Type or print) <i>MARTHA GERTRUDE HUFFINGTON</i>		First	Middle
		Last	
4. DATE OF DEATH		Month	Day
		<i>Oct.</i>	<i>25</i>
		Year	<i>1960</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
			B. DATE OF BIRTH <i>no record</i>
8. AGE (In years (last birthday)		9. IF UNDER 1 YEAR	10. IF UNDER 24 HRS.
<i>375</i> yrs.		Months	Days
10a. LISTED OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>School teacher</i>		<i>Public schools</i>	<i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY?		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>JOHN HUFFINGTON</i>		<i>CAROLINE HAYMAN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>No</i>		<i>Type Caroline Slocum Denton bed.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Rheumatoid Arthritis</i> 10 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		<i>Myocardial Failure</i> 7 days	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>October</i> , 19 <i>50</i> , to <i>October</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>October</i> , 19 <i>60</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>Dawson O. George</i> M.D.		DATE SIGNED <i>October 26, 1960</i>	
PHYSICIAN'S NAME (Type) <i>Dawson O. George</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 27, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Allen</i>
22d. LOCATION (City, town, or county) <i>Allen, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
		DATE <i>OCT 31 '60</i>	

## CERTIFICATE OF DEATH

70051

DECEASED

NAME UNKNOWN

DEATH CERTIFICATE NO. 70051

DEATH DATE UNKNOWN

DEATH PLACE UNKNOWN

DEATH CAUSE UNKNOWN

DEATH TIME UNKNOWN

DEATH AGE UNKNOWN

DEATH GENDER UNKNOWN

DEATH RACE UNKNOWN

DEATH HEIGHT UNKNOWN

DEATH WEIGHT UNKNOWN

DEATH MANNER UNKNOWN

DEATH COORDINATES UNKNOWN

DEATH ADDRESS UNKNOWN

DEATH CITY UNKNOWN

DEATH STATE UNKNOWN

DEATH ZIP CODE UNKNOWN

DEATH COUNTY UNKNOWN

DEATH TOWN UNKNOWN

DEATH STREET UNKNOWN

DEATH NUMBER UNKNOWN

DEATH APARTMENT UNKNOWN

DEATH UNIT UNKNOWN

DEATH FLOOR UNKNOWN

DEATH ROOM UNKNOWN

DEATH BED UNKNOWN

DEATH POSITION UNKNOWN

DECEASED  
NAME UNKNOWNDECEASED  
NAME UNKNOWNDECEASED  
NAME UNKNOWNDECEASED  
NAME UNKNOWNDECEASED  
NAME UNKNOWNDECEASED  
NAME UNKNOWNDECEASED  
NAME UNKNOWN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11211

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11230

Item 8 Film G273 10-26-60 et

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near American Corner</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Rudolph</b>	Middle <b>Adolph</b>	Last <b>Nagel</b>
4. DATE OF DEATH Month <b>October</b>	Day <b>14</b>	Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1916 September 27, 1960
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rudolph Nagel</b>		14. MOTHER'S MAIDEN NAME <b>Anna B. Nagel Seiter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-30-8371</b>	
17. INFORMANT <b>Mrs. Anna B. Nagel</b>		Address <b>RFD Federalsburg</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1960</b> DUE TO <b>Carcinoma of Skull &amp; Thoracic Spine - 1 month</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dr. Dawson O. George</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10-14-60</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 16, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton &amp; Son</b>		ADDRESS <b>Federalsburg</b>	
		24a. REC'D BY REGISTRAR DATE <b>OCT 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

WISCONSIN STATE ENGINEERING COUNCIL—SUBDIVISION OF  
WISCONSIN STATE ENGINEER'S COUNCIL OF DEAN

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be signed by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11212

11226

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>40 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		d. STREET ADDRESS <b>River Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>River Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Julia</b>	Middle <b>Elma</b>	Last <b>Strawberry</b>	4. DATE OF DEATH <b>October 19 1960</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1884</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Noah Hubbard</b>				14. MOTHER'S MAIDEN NAME <b>Ida Holmes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-8391</b>		17. INFORMANT <b>Lillie Prattis</b>		Address <b>1435 W. 7th St., Chester, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO <b>Arteriosclerotic heart disease</b> ? years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1960, to Oct. 19, 1960, that (I) (we) last saw the deceased alive on Oct. 5, 1960, and that death occurred at 6 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. H. R. Trapnell</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct. 21 '60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. R. Trapnell</b>		22d. ADDRESS <b>Federalsburg, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 22, 1960</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Jonestown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Caroline County Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampom &amp; Son</b>		ADDRESS <b>Federalsburg</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11213

**CERTIFICATE OF DEATH**

11227											
1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>2 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Collins Nursing Home</b>											
3. NAME OF DECEASED (Type or print) <b>Ola</b>		First	Middle <b>Virginia</b>	Last <b>Walls</b>	4. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>1960</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1894</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Day <b>0</b>	Year <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Solomon N. Harris</b>		14. MOTHER'S MAIDEN NAME <b>Sarah C. Hall</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>220-03-9489 Mrs. Jane Jarrell</b>		Address <b>Greensboro, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b)		DUE TO  Generalized Arteriosclerosis		Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH					
DUE TO  (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Diabetes Mellitus											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)  <b>Greensboro</b>		(County)  <b>Caroline</b>		(State)  <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 10 1957</b> to <b>Oct. 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 26 1960</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.											
22. SIGNATURE  <i>Charles H. Stonesifer</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>10/27/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22d. ADDRESS  <b>Greensboro, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-28-60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Greensboro</b>		23d. LOCATION (City, town, or county)  <b>Greensboro, Maryland</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE  <i>J. E. Boulosis Greensboro, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 31 '60</b>		25b. REGISTRAR'S SIGNATURE  <i>Arthur S. Trahan</i>					

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